STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135097	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashton Memorial Living Center	700 North Second Street Ashton, ID 83420

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on record review and staff interview, it was determined the facility failed to provide the Advance Beneficiary Notice (CMS-10055 form) for 3 of 3 residents (#7, #19, and #25) reviewed for beneficiary protection notification. This deficient practice had the potential to cause financial harm or distress for residents when they were not informed of their potential liability for payment when their Medicare Part A benefits ended. Findings include: 1. Resident #7 was admitted to the facility on [DATE], with multiple diagnoses including chronic kidney disease and sepsis. A Skilled Nursing Facility Beneficiary Notification Review documented Resident #7's Medicare A benefit ended on 5/23/24. Resident #7's medical record did not include an Advance Beneficiary Notice (ABN). 2. Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including dementia and hypertension. A Skilled Nursing Facility Beneficiary Notification Review documented Resident #19's Medicare A benefit ended on 5/28/24. Resident #19's medical record did not include an Advance Beneficiary Notice (ABN). 3. Resident #25 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including Parkinson's disease (a chronic, progressive brain disorder that affects the nervous system and causes movement problems) and lumbar vertebra fracture. A Skilled Nursing Facility Beneficiary Notification Review documented Resident #25's Medicare A benefit ended on 7/21/24. Resident #25's medical record did not include an Advance Beneficiary Notice (ABN). On 11/6/24 at 11:51 AM, the DNS confirmed the facility had not completed ABNs for Residents #7, #19, and #25 whose Medicare A benefits ended.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on interview and record review, it was determined the facility failed to ensure the MDS assessments accurately reflected residents' status. This was true for 3 of 7 residents (#5, #7, and #14) whose MDS, care plan, and nursing assessments were reviewed. This deficient practice had the potential for negative outcomes if residents were not assessed, cared for, or monitored due to inaccurate assessments. Findings include: Appendix PP of the State Operations Manual, revised 8/8/24, documented the assessment must accurately reflect the resident's status at the time of the assessment. 1. Resident #5 was admitted to the facility on [DATE], and readmitted [DATE], with multiple diagnoses including chronic respiratory failure with hypoxia (occurs when the body does not have enough oxygen in the blood) and atrial fibrillation. Resident #5's MDS assessments, dated 1/30/24, 4/25/24, and 5/17/24, documented her height was 66 inches. Resident #5's MDS assessment, dated 8/16/24, documented her height was 69 inches. On 11/7/24 at 8:00 AM, the DNS stated Resident #5's MDS assessment of height should have been accurate. 2. Resident #7 was admitted to the facility on [DATE], with multiple diagnoses including chronic kidney disease and sepsis. Resident #7's MDS assessment, dated 2/21/24, documented her height was 66 inches. Resident #7's MDS assessments, dated 5/23/24 and 8/22/24, documented her height was 60 inches. On 11/7/24 at 8:02 AM, the DNS stated that Resident #7's MDS assessment of height should have been accurate. 3. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including heart failure, sepsis, and UTI. Resident #14's medical record included a PASARR Level II completed on 11/7/22. A Significant Change in Status assessment, dated 11/8/22, documented Resident #14 had a diagnosis of a serious mental illness and required a PASARR Level II evaluation. On 11/6/23, one year after her PASARR Level II was completed, Resident #14's annual MDS assessment did not document a PASARR Level II evaluation had been completed. On 11/5/24 at 2:20 PM, the DNS confirmed Resident #14's annual MDS assessment, dated 11/6/23, did not document a PASARR Level II evaluation was completed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50983

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on record review, policy review, and staff interview, it was determined the facility failed to refer residents for further evaluation when residents were diagnosed with a major mental illness, intellectual disability, or a related condition. This was true for 1 of 3 residents (Resident #27) reviewed for PASARR Level II evaluations. This deficient practice had the potential to cause harm if resident's specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Findings include: The facility's Admission Criteria policy, dated March 2019, documented, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. Resident #27 was admitted to the facility on [DATE], with multiple diagnoses including heart failure, hypertension, and developmental delay. On 3/15/24, Resident #27's admission MDS assessment documented a diagnosis of development delay. On 11/5/24 at 2:20 PM, the DNS confirmed Resident #27 should have had a PASARR Level II evaluation completed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, policy review, record review, and staff interview, it was determined the facility failed to ensure professional standards of practice for wound care were followed for 1 of 1 resident, (Resident #3), reviewed for wound care. This deficient practice created the potential for resident harm, or adverse outcomes related to infection and skin breakdown. Findings include: The Facility's Wound Care policy, undated, documented under Steps in the Procedure #13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, and date and apply to dressing. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and chronic respiratory failure with hypoxia (which occurs when the body does not have enough oxygen in the blood). On 11/4/24 at 11:16 AM, Resident #3's left leg was observed to have two undated bandages. On 11/7/24 at 8:03 AM, the DNS stated it was the facility policy and expectation that staff date and initial all wound bandages when they are changed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 49552 Based on staff interview and review of employee personal files, it was determined the facility failed to provide a minimum of 12 hours of in-service education per year for 3 of 18 CNAs (#4, #5, and #7) whose personnel records were reviewed. Additionally, the facility failed to ensure each CNA's annual performance reviews were completed at least once every 12 months for 3 of 3 CNAs (#2, #4, and #5) whose personnel records were reviewed for sufficient and competent CNA staffing. This failure created the potential for incompetent CNAs providing care and increased the risk for harm for all residents living in the facility. Findings include: The following personnel records were reviewed on 11/6/24 for 12 hours of in-service education: 1. CNA #4's personnel record documented her hire date was 8/25/14. CNA #4's in-service tracking records did not document in-service hours for 2023 or 2024. 2. CNA #5's personnel record documented her hire date was 12/23/19. CNA #5's in-service tracking records did not document in-service hours for 2023 or 2024. 3. CNA #7's employee file documented her hire date was 4/20/23. CNA #7's in-service tracking records documented she had a total of 1.25 hours for 2023 through 2024. On 11/6/24 at 3:45 PM, the HR Director stated the CNAs should have had the 12-hours of annual in-service education. The following personnel records were reviewed on 11/6/24 for annual performance reviews: 1. CNA #2's personnel record documented her initial hire date was 10/13/20. CNA #2's personnel record did not have documentation an annual evaluation had been completed since she was hired. 2. CNA #4's personnel record documented her hire date was 8/25/14. CNA #4's personnel record documented her last annual evaluation was completed on 10/25/20. 3. CNA #5's personnel record documented her hire date was 12/23/19. CNA #5's personnel record did not have documentation an annual evaluation had been completed since she was hired. On 11/6/24 at 1:47 PM, the HR Director stated employee annual evaluations had not been performed since COVID in 2020. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/7/24 at 8:20 AM, the DNS stated staff evaluations slowed down in 2020 due to COVID, and annual evaluations had not been performed, but should have been.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 51121 Based on observation, document review, and staff interviews, the facility failed to ensure a completed daily staffing sheet had been posted in the nursing facility. This deficient practice had the potential to affect all residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include: On 11/4/24 at 8:00 AM, it was observed the posted facility daily staffing sheet had been left blank. On 11/4/24 at 8:01 AM, the DNS stated the posted facility daily staffing sheet should be completed at the beginning of the shift, which started at 6:00 AM. On 11/4/24 at 9:25 AM, it was observed the posted facility daily staffing sheet remained blank.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, record review, and interview, it was determined the facility failed to obtain an order for prescription medicine. This was true for 1 of 1 resident (Resident #3), reviewed for oxygen usage. This deficient practice created the potential for resident harm or adverse outcomes with the use of non-prescribed medical oxygen. Findings include: Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and chronic respiratory failure with hypoxia (which occurs when the body does not have enough oxygen in the blood). On 11/4/24 at 11:15 AM, an oxygen concentrator was observed in Resident #3's room. On 11/4/24 at 11:16 AM, Resident #3 stated he only used the oxygen at night and when sleeping in his recliner chair. Resident #3's medical record did not include a physician's order for oxygen therapy. Resident #3's progress notes, dated 10/29/24 at 3:03 AM, and 11/3/24 at 3:08 AM, documented, Resident is now asleep in bed with oxygen in place. Resident #3's care plan dated 8/8/24, documented he used, oxygen at night and during the day as needed to keep oxygen saturations >90%. Administer oxygen at 2 liters per minute via nasal cannula nocturnally and as needed. On 11/6/24 at 3:41 PM, the DNS stated the physician had not ordered oxygen for Resident #3 since he was admitted on [DATE], and should have.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were stored appropriately. This was true for the 1 medication storage room inspected. This failure created the potential for misappropriation of residents' medications. Findings include: The facility's Control Substance policy, revised on 11/16/22, documented the facility would comply with all laws, regulations, and other requirements related to the handling, storage, disposal, and documentation of Schedule II and other control substances. On 11/5/24 at 2:05 PM, during an inspection of the medication storage room, with LPN #1 present, the facility's emergency narcotic kit was observed in a plastic box, secured with a plastic zip tie, in an unlocked medication storage refrigerator. On 11/5/24 at 2:11 PM, LPN #1 stated the narcotic emergency kit contained Ativan (a controlled substance used to treat anxiety disorders). She stated the narcotic emergency box should have been double locked. On 11/6/24 at 9:46 AM, the DNS stated narcotics should be double locked.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50983 Based on observation, food code review, and staff interview, it was determined the facility failed to ensure the food was stored in a safe and sanitary manner. These deficiencies had the potential to affect all residents who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include: The FDA (Food Drug Administration) 2022 Food Code, Section 3-501.17 documented on-premises preparation Prepare and hold cold 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. During the initial kitchen inspection conducted on 11/4/24 at 7:54 AM, the following was observed: In the walk-in refrigerator: - loose tomatoes on the shelf with no received or use-by dates - open container of Ranch dressing with no open or use-by date - container of Italian dressing with an open date of 7/23/24, and no use-by date - container of Caesar dressing with an open date of 9/24/24, and no use-by date On 11/4/24 at 8:00 AM, the Food Service Manager stated the tomatoes should have been in a container and dated. She also stated the open dressings should have been dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49552 Based on policy review, observation, and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained to provide a safe and sanitary environment when staff did not offer or encourage residents hand hygiene prior to meals served in their rooms, and follow appropriate cleaning of medical equipment. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: The following hand hygiene issues were observed during meal travel delivery: 1. On 11/4/24 at 8:32 AM, CNA #2 did not encourage Resident #26 to perform hand hygiene before eating. On 11/4/24 at 8:37 AM, CNA #2 stated, I did not offer Resident #26 hand hygiene and I should have. 2. On 11/4/24 at 8:34 AM, CNA #1 did not encourage Resident #21 to perform hand hygiene before eating. On 11/4/24 at 8:40 AM, CNA #1 stated I did not offer hand hygiene to Resident #21 and I should have. 3. On 11/4/24 at 8:44 AM, CNA #3 did not encourage Resident #19 to perform hand hygiene before eating. On 11/4/24 at 8:46 AM, CNA #3 stated she did not offer Resident #19 hand hygiene and I should have. 11/07/24 08:04 AM, the DNS stated the CNAs should have offered hand hygiene to residents who are being served their meals in their rooms. The Facility's Glucometer Cleaning policy, undated, directed staff members to clean and disinfect glucometers after each use. The following was observed for cleaning of medical equipment: On 11/5/24 at 7:37 AM, RN #1 used the glucometer (a device used to measure the amount of glucose in your blood) to check Resident #3's blood sugar. RN #1 placed the glucometer back in the storage box without disinfecting it. On 11/5/24 at 7:46 AM, RN #1 stated the glucometer was Resident #3's personal glucometer, so she did not need to clean it every time it had been used. On 11/6/24 at 9:39 AM, the DNS stated the glucometers were to be cleaned after each use.